MEDICAL EXAMINATION AND HISTORY REPORT

CANDIDATES: Please DO NOT write in "EXAMINING FACILITY USE ONLY" areas.

CANDIDATES: Complete page 1 through 5 before reporting for the medical examination. **Failure to answer any questions or disclose a known medical condition or failure to place signature where indicated may result in disqualification from employment consideration.** Please print or type. Each "yes" answer to a medical history question requires that you provide a brief explanation in the comment section provided. This examination is being conducted for employment purposes only; it does not substitute for a periodic health examination conducted by your private provider.

All mental health counseling must be disclosed on this Medical Examination and History Report form in order to determine if you meet the minimum medical qualifications for the position.

CANDIDATE'S NAME (Last, First, Middle Initial):		SOCIAL SECURITY NUMBER:
VETERAN'S PREFERENCE ELIGIBILITY: ☐ Yes ☐ No	SEX: ☐ Male ☐ Female	DATE OF BIRTH: (mm/dd/yy)
YOUR CURRENT OCCUPATION:	YOUR CURRENT EMPLOYER:	

HOW LONG IN CURRENT POSITION? (years/months)

DESCRIBE TASKS OF YOUR CURRENT POSITION (mainly sedentary, very physically demanding, etc.)

CHECK THE OCCUPATION FOR WHICH YOU ARE BEING CONSIDERED:

☐ Border Patrol Agent ☐ Marine Interdiction Agent

☐ Customs and Border Protection Officer ☐ Other:_____

EXAMINING FACILITY USE ONLY

EXAMINING FACILITIES: **(Do NOT bill examinee for exam. CHS is responsible for all payments.)** Conduct medical exam and all other required services in accordance with instructions provided by the contracting organization. Complete this form except where indicated. Please print or type.

NAME AND ADDRESS OF EXAMINING FACILITY:	DATE OF EXAMINATION:
	NAME OF EXAMINING PHYSICIAN/NP/PA:
	PHONE NUMBER: (including area code)

REQUIRED SERVICES: (check when completed and attach reports)

☐ Medical History and Examiner Review
☐ General Physical Examination (including waist measurements and fitness questionnaire)
☐ Examiner Review and Comments
☐ Audiometry
☐ Repeat Audiometry, if appropriate
☐ Vision Screening

CANDIDATE'S NAME:	SOCIAL SECURITY NUMBER:	DATE:

MEDICAL HISTORY
Candidate Complete This Section

Check "yes" or "no" for **each** item. For each "yes", you must provide an explanation in the space below. **Explanations to "yes" answers must include date, body part affected, description of injury/issue, and type of treatment.**

1. Have you ever been refused employment or been unable to hold a job or stay in school due to any medical condition? (If yes, specify date, where and give details) ☐ Yes ☐ No

2. Have you had any surgery or operation? (If yes, describe and give date, details or problem, and name of procedure) ☐ Yes ☐ No

3. Have you been advised to have any surgery or operation, but chose not to have that treatment? (If yes, describe and give date, details or problem, and name of procedure) ☐ Yes ☐ No

4. Have you ever been a patient in any type of hospital or emergency room? (If yes, specify date, where, why) ☐ Yes ☐ No

5. Have you consulted or been treated by clinics, physicians, healers, or other practitioners other than for minor illness? (If yes, give date and complete details) ☐ Yes ☐ No

6. Have you ever been rejected for or separated from military service because of physical, mental or other medical reasons? (If yes, give date and reason) ☐ Yes ☐ No

7. Have you ever applied for or received VA (Veteran's Administration) disability? (If yes, please attach a copy of all rating decisions, or application if pending decision) ☐ Yes ☐ No

Percentage Granted: _____% Year Granted: _____

Issue and Related Percentage (for example, PTSD 50%, etc.):

8. Have you ever applied for or received pension or compensation for a non VA disability? (If yes, please attach a copy of all rating decisions, or application if pending decision) ☐ Yes ☐ No

Type of Disability (SSDI, Worker's Comp, etc.): _____

Permanent or Temporary: _____ Percentage Granted: _____% Year Granted: _____

Issue and Related Percentage:

9. Are you: ☐ Left Handed OR ☐ Right Handed

CANDIDATE'S NAME:	SOCIAL SECURITY NUMBER:	DATE:

10. Do you take any medications or use inhalers? ☐ Yes ☐ No

If yes, list prescription and non-prescription medications, dosage, and reason for taking (including inhalers).

Medication	Dosage/Frequency	Reason	Currently Taking	Taken in the Last Year
1.			☐	☐
2.			☐	☐
3.			☐	☐
4.			☐	☐

*Attach additional sheets if necessary.

11. Do you have allergies? ☐ Yes ☐ No

If yes, do you carry an Epi pen? ☐ Yes ☐ No

If you have allergies, list substances to which you are allergic, the type of reaction, and any medications taken for treatment. If any allergies are to foods, explain if you can be exposed to them (skin contact) without having a reaction.

What are you allergic to?	Specify the allergy and type of reaction (rash, breathing problem, etc.)	Medications Used
☐ Environmental		
☐ Food (including peppers)		
☐ Insects (bees or other stinging insects)		
☐ Dogs		
☐ Horses		
☐ Medication		

*Attach additional sheets if necessary.

MEDICAL HISTORY
Candidate Complete This Section

Have you ever experienced any of the following? Describe all YES answers on page 5.

12. Diabetes…… ☐ Yes ☐ No
    If yes, treatment consists of:
    ☐ Pills ☐ Insulin ☐ Insulin Pump
    What is the date of onset? _____
13. Hypoglycemia…….... ☐ Yes ☐ No
14. Thyroid disease…….. ☐ Yes ☐ No
15. Pituitary gland problem…….. ☐ Yes ☐ No
16. Blood disorder…… ☐ Yes ☐ No
17. Anemia…… ☐ Yes ☐ No
18. Back pain/injury/surgery…… ☐ Yes ☐ No
19. Neck pain/injury/surgery…… ☐ Yes ☐ No
20. Shoulder pain/injury/surgery…… ☐ Yes ☐ No
21. Arm pain/injury/surgery…… ☐ Yes ☐ No
22. Elbow pain/injury/surgery…… ☐ Yes ☐ No
23. Wrist pain/injury/surgery…… ☐ Yes ☐ No
24. Hand pain/injury/surgery…… ☐ Yes ☐ No
25. Hip pain/injury/surgery…… ☐ Yes ☐ No
26. Leg pain/injury/surgery…… ☐ Yes ☐ No
27. Knee pain/injury/surgery…… ☐ Yes ☐ No
28. Ankle pain/injury/surgery…… ☐ Yes ☐ No
29. Foot pain/injury/surgery…… ☐ Yes ☐ No
30. Loss of joint/limb movement/amputation. ☐ Yes ☐ No
31. Arthritis…… ☐ Yes ☐ No
32. Gout…… ☐ Yes ☐ No
33. Urinary pain/infection/bleeding…… ☐ Yes ☐ No
34. Kidney disease…… ☐ Yes ☐ No
    If yes, specify type of disease _____
35. Kidney stones…… ☐ Yes ☐ No
    If yes, when was last episode?_____
36. Diagnosed migraine headache…… ☐ Yes ☐ No
    If yes, how often? _____
    If yes, are you able to work during a migraine? _____
37. Localized weakness/numbness…… ☐ Yes ☐ No
38. Tingling in head/hands/legs…… ☐ Yes ☐ No
39. Lack of coordination or balance issues... ☐ Yes ☐ No
40. Epilepsy or seizures…….... ☐ Yes ☐ No
    If yes, when was last episode? _____
41. Tremors/shakiness. ……... ☐ Yes ☐ No
42. Fainting/syncope/loss of consciousness/dizziness…….... ☐ Yes ☐ No
43. Traumatic Brain Injury (TBI)…….... ☐ Yes ☐ No
44. Persistent stomach/abdominal pain…….. ☐ Yes ☐ No
45. Diagnosed Irritable Bowel Syndrome (IBS)…….... ☐ Yes ☐ No
46. Diagnosed Inflammatory Bowel Disease (Crohn's Disease, Ulcerative Colitis, etc.)…….... ☐ Yes ☐ No
47. Vomiting blood…….... ☐ Yes ☐ No
48. Persistent diarrhea or constipation…….. ☐ Yes ☐ No
49. Blood in stool…….... ☐ Yes ☐ No
50. Liver disease…….... ☐ Yes ☐ No
51. Fatty liver…….... ☐ Yes ☐ No
52. Hepatitis…….... ☐ Yes ☐ No
    If viral, specify A, B, or C _____
53. Gall bladder problems…….... ☐ Yes ☐ No
54. Hernia…….... ☐ Yes ☐ No
    If yes, hernia type and year repaired
    _____

CANDIDATE'S NAME:	SOCIAL SECURITY NUMBER:	DATE:

55. Mental health treatment, psychotherapy or counseling……..... ☐ Yes ☐ No
56. Diagnosed ADD/ADHD treated in past 10 years……..... ☐ Yes ☐ No
57. Diagnosed ADD/ADHD treated since age 21……..... ☐ Yes ☐ No
58. Diagnosed depression……..... ☐ Yes ☐ No
59. Diagnosed anxiety..…….... ☐ Yes ☐ No
60. Diagnosed PTSD……..... ☐ Yes ☐ No
61. Diagnosed insomnia……..... ☐ Yes ☐ No
62. Any other mental health diagnosis……... ☐ Yes ☐ No
63. Treatment for alcoholism or substance abuse……..... ☐ Yes ☐ No
64. Suicide attempts or plans……..……..... ☐ Yes ☐ No
65. Skin problems and/or Urticaria..……... ☐ Yes ☐ No
66. Organ transplant (e.g. kidney, etc.).…... ☐ Yes ☐ No
67. Heat stroke/heat exhaustion..……..... ☐ Yes ☐ No
68. Rhabdomyolysis…..…….... ☐ Yes ☐ No
69. Cancer diagnosis…..……..... ☐ Yes ☐ No
70. HIV diagnosis……..…….... ☐ Yes ☐ No
71. Cardiac related chest pains……..... ☐ Yes ☐ No
72. Swelling of ankles or feet..…… ☐ Yes ☐ No
73. Peripheral Vascular Disease…….... ☐ Yes ☐ No
74. Mitral valve prolapse..…….... ☐ Yes ☐ No
75. Heart murmur after age 2...……..... ☐ Yes ☐ No
76. History of diagnosis or heart disease..... ☐ Yes ☐ No
77. Coronary bypass surgery/other heart surgery……..…….... ☐ Yes ☐ No
78. Heart palpitations (rapid or skipped heart beat)……..…….... ☐ Yes ☐ No
79. Heart attack or stroke……..... ☐ Yes ☐ No
80. Abnormal electrocardiogram (EKG)..…... ☐ Yes ☐ No
81. Abnormal cardiac stress test..……..... ☐ Yes ☐ No
82. History of high blood pressure..……... ☐ Yes ☐ No
83. History of sleep study……..... ☐ Yes ☐ No
84. History of sleep apnea……..... ☐ Yes ☐ No
85. Do you use a CPAP…….... ☐ Yes ☐ No
86. Diagnosis of hypersomnolence/narcolepsy ……..... ☐ Yes ☐ No
87. Raynaud's Disease……..... ☐ Yes ☐ No
88. Numbness of hands or feet……..... ☐ Yes ☐ No
89. Phlebitis or blood clots……..... ☐ Yes ☐ No
90. Problems with breathing, wheezing, or persistent cough……..…….... ☐ Yes ☐ No
91. History of chronic bronchitis..……..... ☐ Yes ☐ No
92. History of asthma since age 13.……... ☐ Yes ☐ No
    If yes:
    a. Date of last ER visit or hospitalization (or n/a): _____
    b. Do you use maintenance medications? ……..... ☐ Yes ☐ No
    c. Do you use an inhaler?……... ☐ Yes ☐ No
    d. How often is inhaler used? _____ times yearly
    e. When was last used? _____
    f. Inhaler use before certain activities ……..... ☐ Yes ☐ No
    g. What aggravates your asthma? (illness, exercise, etc.)
93. Shortness of breath……..... ☐ Yes ☐ No
94. Previous positive TB skin test……..... ☐ Yes ☐ No
    If yes, have you received treatment. ☐ Yes ☐ No
95. Difficulty hearing……..……..... ☐ Yes ☐ No
96. Ringing or buzzing in ears.……..... ☐ Yes ☐ No
97. Dizziness or balance problems.……..... ☐ Yes ☐ No
98. Chronic ear pain/infection..……..... ☐ Yes ☐ No
99. Eardrum perforation……..... ☐ Yes ☐ No
100. Ear surgery……..……..... ☐ Yes ☐ No
101. Loud, constant noise or music within the past 15 hours ……..... ☐ Yes ☐ No
102. Loud, sudden noise in the past 15 hours ☐ Yes ☐ No
103. Have you been prescribed/do you wear a hearing aid?.....…… ☐ Yes ☐ No
    If yes, specify ____right ____left ____both
104. Color vision problems …… ☐ Yes ☐ No
105. Blurred vision……..…… ☐ Yes ☐ No
106. Diagnosis of night vision deficiency..…… ☐ Yes ☐ No
107. Diagnosis of glaucoma…..…… ☐ Yes ☐ No
108. Diagnosis of cataracts…..…… ☐ Yes ☐ No
109. Keratoconus……..……..…… ☐ Yes ☐ No
110. Diagnosis of any eye disease..…… ☐ Yes ☐ No
111. Have you ever had eye surgery?…… ☐ Yes ☐ No
    (e.g. RK, PRK, LASIK, cataracts, detached retina)
    If yes, specify surgery and date_____
112. Do you wear corrective lenses?…… ☐ Yes ☐ No
113. Do you wear contact lenses?…… ☐ Yes ☐ No
114. Do you use CRT (Corneal Refractive Therapy)/overnight correction lenses? ……..…… ☐ Yes ☐ No
115. Have you ever had, or are you currently being treated for any other illness or injury not already mentioned…….……..…… ☐ Yes ☐ No
    If yes, describe details and dates:
116. Do you have any current lifting restrictions?.....…… ☐ Yes ☐ No
    If yes, describe:
117. Over the past six weeks, on average, how many times per week have you been running? _____ times per week
118. What distance do you run each time? _____ miles
119. How many minutes do you usually run without stopping? _____ minutes
120. Describe your current training regimen for the past month including running (distance, location, frequency), calisthenics (type of exercise and frequency), weight training (type of training, weight used, frequency, duration). Use additional pages as needed.
121. Do you have any residual symptoms with exercise (such as pain, swelling, exercise intolerance)?…. ☐ Yes ☐ No
    If yes, describe symptoms:

CANDIDATE'S NAME:	SOCIAL SECURITY NUMBER:	DATE:

CANDIDATE AND EXAMINER COMMENTS
Candidate and Examiner to Complete This Section

For all "yes" answers from prior pages, explain in detail. Use additional sheets if needed.

APPLICANT			EXAMINER
Question Number	Date of Injury/Date of Diagnosis (month/year)	How injury/illness occurred, symptoms, body part affected, type of treatment, current symptoms, etc.	Examiner's Comments

I certify that the above information provided is complete and correct to the best of my knowledge. I understand that failure to answer any questions or disclose a known medical condition or failure to place signature where indicated may result in disqualification from employment consideration.

CANDIDATE'S SIGNATURE: DATE:

******EXAMINER WILL SIGN OFF ON PAGE 11******

CANDIDATE'S NAME:	SOCIAL SECURITY NUMBER:	DATE:

VISION TESTING
Examiner Complete This Section

DEPTH PERCEPTION

Check Test Used:
☐ **Titmus Stereo** ☐ **Titmus Vision Screener** ☐ **Other**

_____ of _____ total number

Document the number of correct responses above.

_____ Seconds of Arc

OR

_____% Shepard-Fry

PERIPHERAL VISION

Right	***Left***
Temporal ____° Normal: typically 70-90° Nasal ____° Normal: typically 30-60° Total ____°	Temporal ____° Normal: typically 70-90° Nasal ____° Normal: typically 30-60° Total ____°

VISUAL ACUITY TESTING

IF EXAMINEE DOES NOT WEAR CORRECTIVE LENSES: TEST ONLY UNCORRECTED VISION
IF EXAMINEE WEARS CORRECTIVE LENSES: TEST BOTH UNCORRECTED AND CORRECTED VISION
GLASSES/CONTACT LENSES MUST BE REMOVED WHEN TESTING UNCORRECTED VISION

UNCORRECTED VISION (Snellen Units)	***CORRECTED VISION (Snellen Units)***
FAR Both 20/____ Right 20/____ Left 20/____	**FAR** Both 20/____ Right 20/____ Left 20/____
NEAR Both 20/____ Right 20/____ Left 20/____	**NEAR** Both 20/____ Right 20/____ Left 20/____

TEST ADMINISTRATOR PLEASE NOTE: If the vision testing method only tests to 20/200, state "worse than 20/200." Do NOT use symbols (less than "<" or greater than ">") when documenting visual acuity scores.

_____	_____	_____	_____
Printed Name of Examiner	Signature of Examiner	Date	Telephone Number

CANDIDATE'S NAME:	SOCIAL SECURITY NUMBER:	DATE:

COLOR VISION – ISHIHARA TESTING WORKSHEET
This form must be completed by Examiner and accompany all exams.

***Instructions*: Complete one color vision test and provide both the candidate response and normal response.**
Tinted lenses may NOT be used during testing.

14-Plate Ishihara

Plate Number	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**
Candidate Response											Traceable? Yes/No			Trace 2 lines? Yes/No
Normal Response											Traceable? Yes/No			Trace 2 lines? Yes/No

Number of correct responses: _____ of _____ total number

24-Plate Ishihara

Plate Number	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**
Candidate Response															
Normal Response														X	X

Number of correct responses: _____ of _____ total number

38-Plate Ishihara

Plate Number	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**
Candidate Response																					
Normal Response																					

Number of correct responses: _____ of _____ total number

OTHER TEST KIT
Test Name: _____ (Must test at least 14 plates)

Plate Number	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**
Candidate Response																					
Normal Response																					

Number of correct responses: _____ of _____ total number

_____	_____	_____	_____
Printed Name of Examiner	Signature of Examiner	Date	Telephone Number

CANDIDATE'S NAME:	SOCIAL SECURITY NUMBER:	DATE:

AUDIOLOGY
Examiner Complete This Section

DO NOT TEST WITH HEARING AIDS

Right Ear

Canal/external ear: ☐ Normal ☐ Abnormal (if abnormal, describe)

Tympanic/membrane: ☐ Normal ☐ Abnormal (if abnormal, describe)

Left Ear

Canal/external ear: ☐ Normal ☐ Abnormal (if abnormal, describe)

Tympanic/membrane: ☐ Normal ☐ Abnormal (if abnormal, describe)

Daily Calibration Method: ☐ Oscar (machine) ☐ Biological (person)

Yearly Calibration Date:

Frequency	**500 Hz**	**1000 Hz**	**2000 Hz**	**3000 Hz**	**4000 Hz**	**6000 Hz**
Right Ear						
Left Ear						

BODY MEASUREMENTS
Examiner Complete This Section

Height:_____ inches (without shoes)

Weight:_____ pounds (without shoes)

VITAL SIGNS
Examiner Complete This Section

Readings	**Pulse**	**Blood Pressure**
Initial Reading		
Repeat Reading	If initial pulse ≥ 95; wait 15 minutes and recheck	If initial BP ≥ 140/90; wait 15 minutes and recheck

CANDIDATE'S NAME:	SOCIAL SECURITY NUMBER:	DATE:

ORTHOPEDIC CLINICAL EVALUATION
Examiner Complete This Section

Check each item in appropriate column	Normal	Abnormal
Upper extremities		
Shoulders		
Range of motion/flexibility		
Strength/Stability		
Tenderness		
Pain		
Arms		
Strength/Stability		
Tenderness		
Deformity		
Elbow		
Range of motion/flexibility		
Strength/Stability		
Tenderness		
Pain		
Wrist		
Range of motion/flexibility		
Strength/Stability		
Tenderness		
Pain		
Hand/Fingers		
Range of motion/flexibility		
Strength/Stability		
Tenderness		
Pain		
Lower Extremities		
Hips		
Range of motion/flexibility		
Strength/Stability		
Tenderness		
Pain		
Legs		
Strength/Stability		
Tenderness		
Deformity		

Check each item in appropriate column	Normal	Abnormal
Knees		
Range of motion/flexibility		
Strength/Stability		
Tenderness		
Pain		
Ankles		
Range of motion/flexibility		
Strength/Stability		
Tenderness		
Pain		
Feet		
Range of motion/flexibility		
Strength/Stability		
Tenderness		
Pain		
Spine		
Upper Back/Neck		
Range of motion/flexibility		
Strength/Stability		
Tenderness		
Pain		
Mid Back		
Range of motion/flexibility		
Strength/Stability		
Tenderness		
Pain		
Low Back		
Range of motion/flexibility		
Strength/Stability		
Tenderness		
Pain		

*****EXPLAIN **ALL** ABNORMAL ORTHOPEDIC FINDINGS FOUND ABOVE ON PAGE 10 AND 11 (USE ADDITIONAL PAGES IF NEEDED)*

CANDIDATE'S NAME:	SOCIAL SECURITY NUMBER:	DATE:

Examiner Complete This Section

If ANY orthopedic injury or illness has occurred, document the following for each injury. Use additional paper if necessary.

Issue #1: Type of injury/illness (back strain, ankle sprain, carpal tunnel, etc.): _____

- How did the injury/illness occur?
- Date of injury/diagnosis
- Describe treatment, including approximate dates
- Did the candidate lose time from work/school?
- Have all symptoms resolved? If so, when? If not, describe current symptoms, frequency, and when they occur.
- Does the candidate report any current restrictions or limitations because of this issue? If so, describe.
- Does the candidate report any residual symptoms with exercise (e.g., pain, swelling, exercise intolerance, etc.)?
- Additional comments:
- Based on your physical exam, does the candidate appear to have limitations because of this issue? ☐ Yes ☐ No

Issue #2: Type of injury/illness (back strain, ankle sprain, carpal tunnel, etc.): _____

- How did the injury/illness occur?
- Date of injury/diagnosis
- Describe treatment, including approximate dates
- Did the candidate lose time from work/school?
- Have all symptoms resolved? If so, when? If not, describe current symptoms, frequency, and when they occur.
- Does the candidate report any current restrictions or limitations because of this issue? If so, describe.
- Does the candidate report any residual symptoms with exercise (e.g., pain, swelling, exercise intolerance, etc.)?
- Additional comments:
- Based on your physical exam, does the candidate appear to have limitations because of this issue? ☐ Yes ☐ No

CANDIDATE'S NAME:	SOCIAL SECURITY NUMBER:	DATE:

Examiner Complete This Section

If ANY orthopedic injury has occurred, document the following for each injury. Use additional paper if necessary.

Issue #3: Type of injury/illness (back strain, ankle sprain, carpal tunnel, etc.): _____

- How did the injury/illness occur?
- Date of injury/diagnosis
- Describe treatment, including approximate dates
- Did the candidate lose time from work/school?
- Have all symptoms resolved? If so, when? If not, describe current symptoms, frequency, and when they occur.
- Does the candidate report any current restrictions or limitations because of this issue? If so, describe.
- Does the candidate report any residual symptoms with exercise (e.g., pain, swelling, exercise intolerance, etc.)?
- Additional comments:
- Based on your physical exam, does the candidate appear to have limitations because of this issue? ☐ Yes ☐ No

Issue #4: Type of injury/illness (back strain, ankle sprain, carpal tunnel, etc.): _____

- How did the injury/illness occur?
- Date of injury/diagnosis
- Describe treatment, including approximate dates
- Did the candidate lose time from work/school?
- Have all symptoms resolved? If so, when? If not, describe current symptoms, frequency, and when they occur.
- Does the candidate report any current restrictions or limitations because of this issue? If so, describe.
- Does the candidate report any residual symptoms with exercise (e.g., pain, swelling, exercise intolerance, etc.)?
- Additional comments:
- Based on your physical exam, does the candidate appear to have limitations because of this issue? ☐ Yes ☐ No

CANDIDATE'S NAME:	SOCIAL SECURITY NUMBER:	DATE:

CLINICAL EVALUATION
Examiner Complete This Section

Check each item in appropriate column	Normal	Abnormal
Head, face, neck, and scalp (include thyroid)		
Nose		
Sinuses		
Mouth and throat		
Ears – General, ear drums		
Eyes – General, pupils, ocular, motility, nystagmus		
Heart (rhythm, sounds, murmur)		
Lungs and chest		
Vascular system (Varicosities)		
Abdomen and viscera		
Hernia		

Check each item in appropriate column	Normal	Abnormal
Identifying body marks, scars, unique markings other than tattoos		
Skin, lymphatics		
Neurologic		
Deep tendon reflexes		
Balance		
Strength		

*****NOTE **ALL** ABNORMAL FINDINGS BELOW*

PHYSICIAN/NP/PA'S SUMMARY OF SIGNIFICANT MEDICAL FINDINGS AND RECOMMENDATIONS

NOTES: *Describe every abnormality if not already described on previous page(s). Describe in detail, based on history, and exam. Use additional sheets if necessary.*

I have reviewed and discussed the medical history with the candidate.

NAME OF EXAMINING PHYSICIAN/NP/PA: (Please print or type.) ☐ **MD** ☐ **DO** ☐ **NP** ☐ **PA**

PHYSICIAN/NP/PA'S SIGNATURE: **DATE:**